Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC57000080	A. BUILDING: _____ B. WING _____	04/08/2016

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SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

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C 000	INITIAL COMMENTS An unannounced licensure complaint survey, CCR# 20160000932, CCR# 2016002253, CCR#2016002383, CCR# 2016002918, CCR# 2016003021 and CCR#2016003061 was commenced on and concluded on at Sandy Pines Residential Treatment Center for Children and Adolescents. The allegations were substantiated. The facility had deficiencies at the time of the investigation.	C 000	By submitting this Plan of Correction, the Facility does not admit that it violated the regulations. The Facility also reserves the right to amend the Plan of Correction as necessary and to contest the deficiencies, findings, conclusions, and actions of the agency. Immediately following the survey, the CEO and senior management met and developed and planned a course of action to address any identified deficiencies.	
C 018	Operating Standards - Organization All paid personnel and volunteers shall be screened prior to employment, which shall include employment history checks, checks of references, local criminal records checks through local law enforcement agencies, fingerprinting, statewide criminal records checks through the Florida Department of Law Enforcement, and federal criminal records checks through the Federal Bureau of Investigation. Ch 65E-9.005(3)(h)2, F.A.C. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to perform a criminal record screening for 1 of 11 sampled employees prior to the start of employment (Employee C). The findings included: Review on of the facility's policies and	C 018	**Corrective Actions:** The Human Resources Director reviewed and revised policy " Employment Background" to include: • Level I: State criminal background screening required to be completed and evident in HR prior to a potential employee start date • Any conviction for a crime will result in the not being hired • All employees must be re-background screening every 5 years prior to the anniversary date of the prior background screening. The HRD completed a 100% audit of HR files to identify staff who were not in compliance with the 5 year re-background screening. The HRD notified all identified staff that new background screening must be completed by , 2016 or they will be removed from the schedule. The HRD completed an re-audit of all staff who were delinquent in the background screening to ensure that screening had been completed.	, 2016 , 2016 , 2016

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C 018	Continued From page 1 procedures titled, "Employment Background Screening" with the most recent review of documented that the facility would conduct a criminal history search for all employees prior to hire; however, according to the policies and procedures, the criminal history search was noted as "i.e., county(s)or state-wide and/or federal (as necessary)." In addition, the policies and procedures documented that a conviction within the past seven years for a list of crimes "will typically bar a from further consideration of employment." and "A conviction with the past seven (7) years for any other crimes or crimes older than seven (7) years may also bar a from employment. During observation and interview with Nurse Manager on the Pelican unit on at 9:28 AM, the Nurse Manager reported that all scheduled staff were present on the units and review of the schedule revealed that Employee C was scheduled to work as a Program Supervisor on the Pelican Unit at that time. Review on of Employee C's personnel file, revealed that the employee, a Mental Health Tech (MHT) Supervisor had a hire date of ; however, there was no evidence that the facility obtained a criminal record screening for the employee prior to hire. In an interview conducted on at 3:16 PM with the Human Resource (HR) Manager, the HR Manager was informed that the criminal record screening for the employee could not be located; she reported that she would look for it. The HR Manager reported in an interview conducted on at 3:54 PM that she had been unable to locate any evidence of documentation of Employee C's criminal record screening.	C 018	**Monitoring:** The HRD implemented an ongoing tracking system that identifies the background expiration dates for all current staff. Notification will sent to the individual staff member and his/her immediate supervisor 30 days prior to expiration that the background screening must be done within the next 2 weeks to ensure that it is completed and cleared before the employee's expiration date. Data regarding ongoing compliance will be reported to the Performance Improvement Committee on a quarterly basis. Responsible Person: Human Resource Director	, 2016

Agency for Health Care Administration

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C 022	Continued From page 2	C 022		
C 022	Operating Standards - Organization Accurate and complete personnel records shall be maintained on each employee. Content shall include: a. Current background information, including the application, references, proof of satisfactory background screening results as required by Section 394.4572, F.S., and documentation to justify initial and continued employment of the individual. Applicants for positions requiring licensure, certification or accreditation shall be employed only after the provider has verified the license or accreditation. Evidence of renewal of license as required by the licensing agent shall be maintained in the employee's personnel record; b. Current performance evaluation; c. Record of any continuing education or staff development programs completed. Ch 65E-9.005(3)(h)6, F.A.C. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to obtain proof of satisfactory Background Screening results every five years to justify continued employment for 5 of 11 sampled direct care employees (Employee A, D, G, H, and J). The findings included:	C 022	**Corrective Actions:** The Human Resources Director reviewed and revised policy " Employment Background" to include: • Level I: State criminal background screening required to be completed and evident in HR prior to a potential employee start date • Any conviction for a crime will result in the not being hired • All employees must be re-background screening every 5 years prior to the anniversary date of the prior background screening. The HRD completed a 100% audit of HR files to identify staff who were not in compliance with the 5 year re-background screening. The HRD informed all identified staff that new background screening must be completed by , 2016 or they will be removed from the schedule The HRD completed a re-audit of all staff who were delinquent in the background screening to ensure that screening had been completed.	May 4, 2016 , 2016 , 2016 , 2016

Agency for Health Care Administration

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C 022	Continued From page 3 Review on of the facility's policies and procedures titled, "Employment Background Screening" with the most recent review of revealed that the policies and procedures failed to address how the facility planned to obtain and maintain the documentation required for continued employment. Review on of the personnel records for Employee A, D, G, H, and J revealed the following: a) Employee A, a Mental Health Technician (MHT) Supervisor had an employment start date of with the facility. The personnel file revealed that the employee's most recent Background Screening was dated . There was no evidence of documentation to justify the employee's continued employment. b) Employee D, a MHT had an employment start date of . The personnel file revealed that the employee's most recent Background Screening was dated . There was no evidence of documentation to justify the employee's continued employment. c) Employee G, a MHT had an employment start date of . The personnel file revealed that the most recent background screening was dated . There was no evidence of documentation to justify the employee's continued employment. d) Employee H, a MHT had an employment start date of . The personnel file revealed that the most recent background screening was dated . There was no evidence of documentation to justify the employee's continued employment. e) Employee J, a MHT had an employment start date of . The personnel file revealed that the most recent background screening was dated . There was no evidence of documentation to justify the employee's continued	C 022	Monitoring: The HRD implemented an ongoing tracking system that identifies the background expiration dates for all current staff. Notification will sent to the individual staff member and his/her immediate supervisor 30 days prior to expiration that the background screening must be done within the next 2 weeks to ensure that it is completed and cleared before the employee's expiration date. Data regarding compliance will be reported to the Performance Improvement Committee on a monthly basis. Responsible Person: Human Resources Director	, 2016

Agency for Health Care Administration

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C 022	Continued From page 4 employment. In an interview conducted on at 3:16 PM with the facility's Human Resource (HR) Manager, the HR Manager was informed of the lack of documentation to justify their employee's continued employment. The HR Manager reported in an interview conducted on at 3:54 PM that she had been unable to locate any evidence of documentation to justify their employee's continued employment.	C 022		
C 154	Treatment Planning The provider shall review the treatment plan within 30 days of admission and at least monthly thereafter with input from the child and parent or guardian, guardian ad litem, and other stakeholders (e.g.; child welfare or community based care case manager, other community agencies or organizations) to assess the appropriateness and suitability of the child ' s placement in the program, to evaluate the child ' s progress toward treatment goals, to review and modify, when necessary, the treatment plan and treatment approaches, to review and update the discharge plan and to determine if the child is ready to move to a less restrictive placement. Chapter 65E-9.009(5), F.A.C. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to update the treatment plan for 1 of 17 sampled residents after a planned intervention was documented as needed (Resident #2). The findings include:	C 154	**Corrective Actions:** The Director of Clinical Services reviewed and revised policy "Treatment Planning", to include: • Treatment plans are reviewed and modified as needed for every incident of and/or as part of the post event evaluation and any other newly identified problems, interventions and revisions of goals and interventions to previously identified problems by the staff who identified the need for this addition to the treatment plan • Revisions to the Master treatment plans to include newly identified Problem , goal, interventions will be addressed at the weekly clinical review • The revision will be included in the Master Treatment Plan Update every 30 days	, 2016

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C 022	Continued From page 4 employment. In an interview conducted on at 3:16 PM with the facility's Human Resource (HR) Manager, the HR Manager was informed of the lack of documentation to justify their employee's continued employment. The HR Manager reported in an interview conducted on at 3:54 PM that she had been unable to locate any evidence of documentation to justify their employee's continued employment.	C 022	C 154 Continued	
C 154	Treatment Planning The provider shall review the treatment plan within 30 days of admission and at least monthly thereafter with input from the child and parent or guardian, guardian ad litem, and other stakeholders (e.g.; child welfare or community based care case manager, other community agencies or organizations) to assess the appropriateness and suitability of the child ' s placement in the program, to evaluate the child ' s progress toward treatment goals, to review and modify, when necessary, the treatment plan and treatment approaches, to review and update the discharge plan and to determine if the child is ready to move to a less restrictive placement. Chapter 65E-9.009(5), F.A.C. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to update the treatment plan for 1 of 17 sampled residents after a planned intervention was documented as needed (Resident #2). The findings include:	C 154	The Director of Clinical Services/designee conducted staff education of all nurses, , MHTs via class training with a post test on the revised policy which included: • Treatment plans are reviewed and modified as needed for every incident of and/or as part of the post event evaluation and any other newly identified problems, interventions and revisions of goals and interventions to previously identified problems by the staff who identified the need for this addition to the treatment plan • Revisions to the Master treatment plans to include newly identified Problem , goal, interventions will be addressed at the weekly clinical review • The revision will be included in the Master Treatment Plan Update every 30 days	, 2016

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C 154	Continued From page 5 Review on of Resident #2's record revealed that the resident was involved with a peer on and the treatment notes documented that the resident would have a "boundaries goal" added to their treatment plan; however, there was no evidence of documentation that the facility added this goal. In an interview conducted on at 1:54 PM with the Risk Manager and the Nurse Manager, the participants acknowledged the findings.	C 154	**C 154 Continued** **Monitoring:** • The Director of Clinical Services implemented a 100% review process of all clinical staff review documents to ensure that the Treatment plans are reviewed and modified as needed for every incident of and/or as part of the post event evaluation and any other newly identified problems, interventions and revisions of goals and interventions to previously identified problems by the staff who identified the need for this addition to the treatment plan. The aggregated data will be reported monthly to the Performance Improvement Committee. Non-compliance will be addressed with 1:1 education/counseling with the individual staff member. **Responsible Person:** Director of Clinical Services	, 2016
C 170	Discharge & Discharge Planning A child may be discharged only to the parent, guardian or placing organization, unless the provider is otherwise ordered by the court. Chapter 65E-9.011(6), F.A.C. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to discharge 1 of 17 sampled residents to the parent, guardian or placing organization (Resident #16). The findings included: Review on of the facility's policies and procedures titled, "Discharge Criteria" with the most recent review of documented that the facility enforced "administrative/discharge/discharge to another setting" when the resident's "violent or other behavior that cannot be managed within the facility, as determined by the treatment team." The facility's policies and procedures titled, "Continuity of Care" with the most recent review	C 170	**Corrective Actions:** The Director of Clinical Services reviewed and revised policy, "Continuity of Care" to include: • The assigned or designee will notify the legal guardian and if applicable the placing organization to inform him/her that the resident has been • The resident will be reassessed for admission based upon collateral clinical information from the Receiving facility to determine if the resident meets admission criteria • If the resident no longer meets admission criteria, the assigned therapist/designee will contact the Receiving facility and legal guardian to assist in the coordination of the previous defined discharge plan • The assigned /designee will document in the clinical notes all the above interactions	, 2016

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C 170	Continued From page 6 of documented that a hospitalization such as a was a discharge and the policies and procedures failed to address re-admission to the facility after a Review of Resident #16's record on revealed that the resident was admitted to the facility on . The resident's record, including notes dated revealed that the resident's discharge plan included staying in the facility for several more months, until the resident became , then an extended . The resident's record, including notes dated documented that the resident was in agreement with the discharge plan. However, the record documented that the resident was discharged via a to a hospital on , after several altercations in the facility and the resident has not returned to the facility. In an interview conducted on at 10:57 AM with the Administrator, the Administrator reported that the facility discussed the resident with a facility Psychiatrist and the team decided to not re-admit the resident; explained that the resident's behavior on caused the staff to feel that the resident's readmission to the facility "would jeopardize everyone's treatment here and be a risk to staff in terms of safety;\" and reported that the facility informed the receiving hospital that the facility would not readmit the resident.	C 170	The Director of Clinical Services/designee educated staff (nurses, MHTs,) via class training on the policy revision to include: • The assigned or designee will notify the legal guardian and if applicable the placing organization to inform him/her that the resident has been • The resident will be reassessed for admission based upon collateral clinical information from the Receiving facility to determine if the resident meets admission criteria • If the resident no longer meets admission criteria, the assigned /designee will contact the Receiving facility and legal guardian to assist in the coordination of the previous defined discharge plan • The assigned /designee will document in the clinical notes all the above interactions Monitoring: The Director of Clinical Services implemented a 100% review process of all residents who were discharged from admission due to no longer meeting criteria to ensure that coordination of the discharge plan was evident. The aggregated data will be reported monthly to the Performance Improvement Committee Responsible Person: Director of Clinical Services	, 2016 , 2016
C 185	Rights of Children - Child & neglect The provider shall require each paid and volunteer staff member, upon hiring and every 12 months thereafter, to read and sign a statement summarizing the child and neglect laws and outlining the staff member's responsibility to	C 185		

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C 185	Continued From page 7 report all incidents of child and neglect. Such signed statements shall be placed in each employee ' s personnel file. Chapter 65E-9.012(3)(d), F.A.C. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to require that every 12 months after hiring, to read and sign a statement summarizing the child and neglect laws and outlining the staff member's responsibility to report all incidents of child and neglect for 10 of 10 sampled direct care employees (Employee A, B, C, D, E, F, G, H, I and J). The findings included: Review on of the facility's policies and procedures titled, " Reporting" with the most recent revision of revealed that the policies and procedures documented that "All staff members will be educated during Orientation upon hire." The policies and procedures failed to address the requirement for each employee to read and sign a statement summarizing the child and neglect laws and outlining the staff member's responsibility to report all incidents of child and neglect every 12 months after hire. Review on of the employee files for 10 sampled employees, Employee A, B, C, D, E, F, G, H, I and J who have direct contact with the residents, revealed that all employees had been working for the facility for more than 12 months; however, there was no evidence of documentation that the facility requested the employees to read and sign, every 12 months	C 185	**Corrective Actions:** The Human Resources Director reviewed and revised policy, " Reporting" to define: • The requirement that and neglect laws will be conducted for all staff every 12 months. • As part of the training, staff are required to sign and date an attestation verifying that they have received and neglect training and will adhere to the requirements. The Risk Manager/designee conducted training of all current facility staff on the and neglect laws . Competency was evaluated with a post test. The Human Resources Director revised the orientation training requirements to include of and neglect. The Human Resources Director reconciled the attestations against the current active employee roster to ensure 100% participation Monitoring: The Human Resources Director implemented an ongoing tracking system to ensure that training is done every 12 months. Noncompliance will be reported to the Immediate supervisor. Noncompliant staff will be removed from duty until they complete the mandatory training. Aggregated Data will be reported to the Performance Improvement Committee quarterly. **Responsible Person:** Human Resources Director	, 2016 , 2016 , 2016 , 2016

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C 185	Continued From page 8 after hire, a statement summarizing the child and neglect laws and outlining the staff member's responsibility to report all incidents of child and neglect. In an interview conducted on at 2:19 PM with the Human Resources (HR) Director, the HR Director reported that the facility had been without an HR Director for several months and the HR Director coordinated the training for employees.	C 185		
C 200	Restraint/Seclusion/Time-Out - Authorization or shall be used and continued only pursuant to an order by a board certified or board eligible psychiatrist licensed under Chapter 458, F.S., or licensed physician with specialized training and experience in diagnosing and treating mental and who is the child's treatment team physician. If the child's treatment team physician is unavailable, the physician covering for the treatment team physician may meet these qualifications. Physicians allowed to order and , pursuant to this rule, must be trained in the use of emergency safety interventions prior to ordering them. Chapter 65E-9.013(3)(a), F.A.C. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to obtain a physician's order for the use of for 2 of 17 sampled residents reviewed for seclusions and (Resident #16 and #17). The findings included:	C 200	**Corrective Actions:** , 2016 The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or seclusion - Requirement to obtain a physician's order for any use of and/or seclusion - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or seclusion - Requirement to fully document each use of and/or seclusion - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention	

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C 200	Continued From page 9 1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented, "The use of or must be authorized by an RN (Registered Nurse) and/or MD (Medical Doctor) based on his/her clinical assessment of the resident. The RN may authorize the use of or for up to one hour in an emergency safety situation [...]". The policies and procedures documented the treatment team psychiatrist, if on site, to assess the resident and write the necessary orders, "If the treatment team psychiatrist is not available on site, a verbal telephone order shall be obtained by the RN from the psychiatrist, or covering psychiatrist, within 30 minutes after initiation of the emergency intervention." Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines; The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of	C 200	**C 200 Continued** - Requirement to document the names of all staff involved in the and/or - Need to consult with the resident's treatment team physician for the and to document that consultation including the date/time of the consult. - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification - Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /seclusion. - Requirement to complete and document a debriefing session within	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 200	Continued From page 9	C 200	**C 200 Continued**	

1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented, "The use of or must be authorized by an RN (Registered Nurse) and/or MD (Medical Doctor) based on his/her clinical assessment of the resident. The RN may authorize the use of or for up to one hour in an emergency safety situation [...]". The policies and procedures documented the treatment team psychiatrist, if on site, to assess the resident and write the necessary orders, "If the treatment team psychiatrist is not available on site, a verbal telephone order shall be obtained by the RN from the psychiatrist, or covering psychiatrist, within 30 minutes after initiation of the emergency intervention."
Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies.
Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines; The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of

24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of restraint/seclusion. If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /

The DON and and revised all medical records forms related to the documentation of the use of / to ensure that all required elements could be documented correctly and thoroughly. **3, 2016**

The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on:
- Definition of and appropriate justification for use of and/or during for an emergency safety situation
- Revisions/clarifications to the / Policy including:
  - Who may authorize the use of and/or seclusion
  - Requirement to obtain a physician's order for any use of and/or

8, 2016

Agency for Health Care Administration

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	RC57000060	A. BUILDING: _____ B. WING _____	04/08/2016

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Agency for Health Care Administration

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C 200	Continued From page 9	C 200	**C 200 Continued**	

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Monitoring:

The DON/designees and/or the RM review 100% of all documents related to the use of /seclusion on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. , 2016

For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented /restraint to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. , 2016 and ongoing

Responsible:
Director of Nursing

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C 200	Continued From page 10	C 200		

any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked; they were observed pacing back and forth in the area and this lasted at least 5 minutes.

Review of Resident #16's record, on revealed that the resident was admitted to the facility on . The record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record further revealed evidence of documentation that the facility discharged the resident, at that time. Continued review of the resident's record revealed no evidence of documentation that staff documented the ( ) intervention in the resident's record, no evidence of documentation that the facility obtained a physician's order for the on

2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence of documentation that staff documented the ( ) intervention in the resident's

Agency for Health Care Administration

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C 200	Continued From page 11 record, including no evidence of documentation that the facility obtained a physician's order for the of . In an interview conducted on at 12:03 PM with the facility's own Risk Manager, the facility's own Risk Manager reported that the facility was a locked facility and the units were also locked and she inquired whether this was a .	C 200		
C 207	Restraint/ /Time-Out - Authorization If a child requires the use of or at any time during their stay, the treatment team shall formally review and actively address their use during the child's regularly scheduled treatment team review meetings, no less frequently than two times per month, until deemed no longer necessary. The reviews shall assess the frequency, patterns and trends. and identify ways to prevent the need for and use. The treatment team's review of and efforts to eliminate and use with a specific child shall be documented as part of the child's treatment team review. In addition, if a child is restrained a total of two times within a thirty day period, or is in a total of three times within a thirty day period, the treatment team will oversee the development and monitor the implementation of a formal child-specific plan to aggressively address the need for and use with that child. Chapter 65E-9.013(3)(h), F.A.C. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	C 207	**Corrective Action:** The Director of Clinical Services reviewed and revised policy "Treatment Planning", to include: • Treatment plans are reviewed and modified as needed for every incident of and/or as part of the post event evaluation and any other newly identified problems, interventions and revisions of goals and interventions to previously identified problems by the staff who identified the need for this addition to the treatment plan • Revisions to the Master treatment plans to include newly identified Problem , goal, interventions will be addressed at the weekly clinical review • The revision will be included in the Master Treatment Plan Update every 30 days • In the event the resident has 2 in a 30 day period or is in within a thirty day period, the treatment team will develop and implement a formal resident specific plan that addresses the need for and	, 2016

Agency for Health Care Administration

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C 207	Continued From page 12 failed to review the treatment plan no less frequently than twice a month for 3 of 17 sampled residents (Resident #1, #2 and #5) who had The findings included. 1. Review on of Resident #1's record revealed that the resident had on , on , twice on , on and on ; however, the resident's record failed to reveal any evidence of documentation that the facility reviewed the resident's treatment plan no less frequently than twice a month following the interventions and address the interventions. 2. Review on of Resident #2's record revealed that the resident had a on ; however, the resident's record failed to reveal any evidence of documentation that the facility reviewed the resident's treatment plan no less frequently than twice a month following the intervention and address the intervention. 3. Review on of Resident #5's record revealed that the resident had on , , , , , and ; however, the resident's record failed to reveal any evidence of documentation that the facility reviewed the resident's treatment plan no less frequently than twice a month following the interventions and address the interventions. In an interview conducted on at 11:30 AM with the Clinical Director and the Risk Manager, the participants acknowledged the findings.	C 207	The Director of Clinical Services conducted staff education via class training on the revised policy. **Monitoring:** The Director of Clinical Services implemented a 100% review process of all clinical staff review documents to ensure that the revision is evident. **Responsible Person:** Director of Clinical Services	, 2016 , 2016

Agency for Health Care Administration

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C 208	Continued From page 13	C 208		
C 208	Restraint/Seclusion/Time-Out - Authorization Within one hour of the initiation of or , the ordering physician or other licensed practitioner, as permitted by the state and facility, (including a nurse, advanced nurse practitioner, physician assistant, or registered nurse) trained in the use of emergency safety interventions, shall conduct a face-to-face assessment of the physical and well being of the child, including: 1. The child ' s physical and status; 2. The child ' s current behavior; 3. The appropriateness of the intervention measures; and 4. Any physical or complications resulting from the intervention. Chapter 65E-9.013(3)(i), F.A.C. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to have a Registered Nurse or Physician conduct a face to face assessment of the resident, to include the required assessments, within one hour of the initiation of a for 2 of 17 sampled residents reviewed for seclusions and (Resident #16 and #17). The findings included: 1. Review on of the facility's policies and	C 208	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager (RM) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the restraint and/or seclusion - Requirement to fully document each use of and/or - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or - Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult.	, 2016 , 2016

Agency for Health Care Administration

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C 208	Continued From page 14 procedures titled, " and " with the most recent review of revealed that the policies and procedures documented that a Registered Nurse (RN) conduct a face to face assessment assessment of the resident within an hour of the initiation of a or . Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after	C 208	**C 208 Continued** - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification - Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of / . - Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. - Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / .	

Agency for Health Care Administration

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C 208	Continued From page 14	C 208	**C 208 Continued**	

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Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on .
The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after

The DON and and revised all medical records forms related to the documentation of the use of restraint/ to ensure that all required elements could be documented correctly and thoroughly.

The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on:

- Definition of and appropriate justification for use of and/or during for an emergency safety situation
- Revisions/clarifications to the Restraint/Seclusion Policy including:
  - Who may authorize the use of and/or
  - Requirement to obtain a physician's order for any use of and/or
  - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or
  - Requirement to fully document each use of and/or
  - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention
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C 208	Continued From page 14	C 208	**C 208 Continued**	

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- Need to consult with the resident's treatment team physician for the and to document that consultation including the date/time of the consult.
- Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation
- Need to notify the resident's legal guardian that the resident had a and/or and document that notification
- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /seclusion.

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C 208	Continued From page 14	C 208	**C 208 Continued**	

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Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on .
The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after

- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of restraint/ . If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / .
- Revisions to the /Seclusion forms
- Documentation requirements related to restraint/
- Expectations for full compliance to the / policy and documentation requirements.

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC57000060	A. BUILDING: _____ B. WING _____	04/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 208	Continued From page 14 procedures titled, " and " with the most recent review of revealed that the policies and procedures documented that a Registered Nurse (RN) conduct a face to face assessment assessment of the resident within an hour of the initiation of a or . Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after	C 208	**C 208 Continued** Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work.	

Agency for Health Care Administration

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C 208	Continued From page 15 the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence of documentation that staff documented the ( ) intervention in the resident's record, including no evidence of documentation that a RN conducted a face to face assessment of the resident within one hour of the initiation of the to include the the required assessments. 2. Review of Resident #17's record on that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facilty re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence of documentation that staff documented the ( ) intervention in the resident's record, including no evidence of documentation that a RN conducted a face to face assessment of the resident within one hour of the initiation of the to include the the required assessments. In an interview conducted on at 12:03 PM with the facility's Risk Manager, the facility's Risk Manager reported that the facility was a locked facility and the units were also locked and she inquired whether this was a .	C 208	**C 208 Continued** **Monitoring:** The DON/designees and/or the 100% of all documents related to the use of / on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. For a period of four months, the DON and are conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented /restraint to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	, 2016 and ongoing

Agency for Health Care Administration

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C 210	Continued From page 16	C 210	**Corrective Actions:**	
C 210	Restraint/ /Time-Out - Documentation Documentation. Staff shall document the intervention in the child ' s record, with documentation completed by the end of each shift during which the intervention begins and continues. Documentation shall include: (a) Each order for or ; (b) The time the emergency safety intervention began and ended; (c) The specific circumstances of the emergency safety situation, the rationale for the type of intervention selected, the less intrusive interventions that were considered or tried and the results of those interventions; (d) Time-specific assessments of the child ' s physical and condition; (e) The name, position, and credentials of all staff involved in or witnessing the emergency safety intervention; (f) Time and date of notification of the child ' s parent or guardian and guardian ad litem; (g) The behavioral criteria and assistance provided by staff to help the child meet the criteria for discontinuation of or ; (h) Summary of debriefing of the child with staff; (i) Description of any injuries sustained by the child during or as a result of the or emergency safety intervention and treatment received for those injuries;	C 210	The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of and and to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or - Requirement to fully document each use of and/or - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or - Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult. - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation	

Agency for Health Care Administration

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C 210	Continued From page 17 (j) Review and revise, if necessary, the child ' s treatment plan, including a description of procedures designed to prevent the future need for and use of or ; and (k) Before or were ordered for the child, the ordering physician assessed whether there were pre-existing medical conditions or physical , history of or , or current use of medication that could present a risk to the child and results of such review are documented in the order for or and the child ' s record. Chapter 65E-9.013(4), F.A.C. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to document a in the resident's record for 2 of 17 sampled residents reviewed for seclusions (Resident #16 and #17) and failed to document a in the resident's record for 1 of 17 sampled residents reviewed for (Resident #5). The findings included: 1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for /Seclusion" packet for each / episode by the end of the shift. Documentation must be completed within	C 210	**C 210 Continued** - Need to notify the resident's legal guardian that the resident had a and/or and document that notification - Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of / - Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. - Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / . The DON and and revised all medical records forms related to the documentation of the use of /seclusion to ensure that all required elements could be documented correctly and thoroughly.	, 2016

Agency for Health Care Administration

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C 210	Continued From page 17 (j) Review and revise, if necessary, the child ' s treatment plan, including a description of procedures designed to prevent the future need for and use of or ; and (k) Before or were ordered for the child, the ordering physician assessed whether there were pre-existing medical conditions or physical , history of or , or current use of medication that could present a risk to the child and results of such review are documented in the order for or and the child ' s record. Chapter 65E-9.013(4), F.A.C. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to document a in the resident's record for 2 of 17 sampled residents reviewed for (Resident #16 and #17) and failed to document a in the resident's record for 1 of 17 sampled residents reviewed for (Resident #5). The findings included: 1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for /Seclusion" packet for each / episode by the end of the shift. Documentation must be completed within	C 210	C 210 Continued The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: - Definition of and appropriate justification for use of and/or during for an emergency safety situation - Revisions/clarifications to the / Policy including: • Who may authorize the use of and/or • Requirement to obtain a physician's order for any use of and/or • Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or • Requirement to fully document each use of and/or • Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention • Requirement to document the names of all staff involved in the and/or • Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult.	, 2016

Agency for Health Care Administration

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C 210	Continued From page 17 (j) Review and revise, if necessary, the child ' s treatment plan, including a description of procedures designed to prevent the future need for and use of or ; and (k) Before or were ordered for the child, the ordering physician assessed whether there were pre-existing medical conditions or physical , history of or , or current use of psychotropic medication that could present a risk to the child and results of such review are documented in the order for or and the child ' s record. Chapter 65E-9.013(4), F.A.C. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to document a in the resident's record for 2 of 17 sampled residents reviewed for seclusions (Resident #16 and #17) and failed to document a in the resident's record for 1 of 17 sampled residents reviewed for (Resident #5). The findings included: 1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for /Seclusion" packet for each / episode by the end of the shift. Documentation must be completed within	C 210	C 210 Continued • Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation • Need to notify the resident's legal guardian that the resident had a and/or and document that notification • Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /	

Agency for Health Care Administration

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C 210	Continued From page 17 (j) Review and revise, if necessary, the child ' s treatment plan, including a description of procedures designed to prevent the future need for and use of or ; and (k) Before or were ordered for the child, the ordering physician assessed whether there were pre-existing medical conditions or physical , history of or , or current use of medication that could present a risk to the child and results of such review are documented in the order for or and the child ' s record. Chapter 65E-9.013(4), F.A.C. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to document a in the resident's record for 2 of 17 sampled residents reviewed for seclusions (Resident #16 and #17) and failed to document a in the resident's record for 1 of 17 sampled residents reviewed for (Resident #5). The findings included: 1. Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "complete the Justification for Restraint/Seclusion" packet for each episode by the end of the shift. Documentation must be completed within	C 210	**C 210 Continued** • Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of restraint/seclusion. If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. • Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / - Revisions to the Restraint/Seclusion forms - Documentation requirements related to restraint/seclusion - Expectations for full compliance to the Restraint/Seclusion policy and documentation requirements.	

Agency for Health Care Administration

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C 210	Continued From page 18 the shift during which the intervention took place." Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence of documentation that staff	C 210	**C 210 Continued** Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work.	

Agency for Health Care Administration

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C 210	Continued From page 19 documented the intervention in the resident's record. 2. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence of documentation that staff documented the intervention in the resident's record. In an interview conducted on at 12:03 PM with the facility's Risk Manager, the facility's Risk Manager reported that the facility was a locked facility and the units were also locked and she inquired whether this was a . 3. Review on of Resident #5's record revealed evidence of documentation of a on at 3:30 PM and the resident accused staff of spitting on the resident. The resident's record revealed evidence of documentation of a "monthly district staffing," dated that documented the resident was "restrained yesterday" and no additional information/packet documentation related to the intervention. During a review on at approximately 4:45 PM, of the facility's video recording of the occurrence and interview with the facility's Risk Manager, the facility's Risk Manager reported that	C 210	**C 210 Continued** **Monitoring:** The DON/designees and/or the 100% of all documents related to the use of / on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	, 2016 and ongoing

Agency for Health Care Administration

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C 210	Continued From page 20 she could not locate any video recording of the occurrence or additional information. In an interview conducted on at 12:03 PM with the facility's Risk Manager, the facility's Risk Manager acknowledged the finding.	C 210		
C 213	Restraint/Seclusion/Time-Out - Notification Notification of use of or 1. As soon as possible, but no later than 24 hours after the initiation of each emergency safety intervention, the provider shall notify the parent or guardian that the child has been restrained or placed in 2. The provider shall document in the child ' s record that the parent or guardian was notified, including the date and time of notification and the name of the staff person providing the notification. Chapter 65E-9.013(6)(b), F.A.C. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to notify the resident's legal guardians that the residents had a for 2 of 17 sampled residents reviewed for and (Resident #16 and #17). The findings included: Review on of the facility's own policies and procedures titled, " and " with the most recent review of revealed that the policies and procedures documented a Registered Nurse (RN) to "notify the resident's	C 213	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and and - Who may authorize the use of and/or - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or - Requirement to fully document each use of and/or - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or	, 2016

Agency for Health Care Administration

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C 213	Continued From page 21	C 213	**C 213 Continued**	

parent or guardian of the or , as soon as possible after the initiation of the or . The RN must document this notification to include name of guardian notified, type of notification, RN's signature and date/time of notification."
Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies.

Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes.
Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on .
The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on

- Need to consult with the resident's treatment team physician for the and to document that consultation including the date/time of the consult.
- Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation
- Need to notify the resident's legal guardian that the had a restraint and/or seclusion and document that notification
- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /
- Requirement to complete and document a debriefing session within 24 hours after use of and/or

Agency for Health Care Administration

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	RC57000060	A. BUILDING: _____ B. WING _____	04/08/2016

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C 213	Continued From page 21 parent or guardian of the or , as soon as possible after the initiation of the or . The RN must document this notification to include name of guardian notified, type of notification, RN's signature and date/time of notification." Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on	C 213	**C 213 Continued** with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. - Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / The DON and and revised all medical records forms related to the documentation of the use of restraint/ to ensure that all required elements could be documented correctly and thoroughly. , 2016 The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: - Definition of and appropriate justification for use of and/or during for an emergency safety situation - Revisions/clarifications to the Restraint/Seclusion Policy including: • Who may authorize the use of and/or • Requirement to obtain a physician's order for any use of and/or , 2016	

Agency for Health Care Administration

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C 213	Continued From page 21	C 213	**C 213 Continued**	

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Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes.
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- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of / .
- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / , if an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
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Agency for Health Care Administration

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Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on

- Revisions to the / forms
- Documentation requirements related to /seclusion
- Expectations for full compliance to the /Seclusion policy and documentation requirements.

Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work.

Agency for Health Care Administration

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C 213	Continued From page 22 accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including no evidence of documentation that the facility notified the resident's guardian of the 2. Review of Resident #17's record on revealed that the resident was admitted to the on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including no evidence that the facility notified the resident's guardian of the In an interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility; the units were also locked and she inquired whether this was a	C 213	**C 213 Continued** **Monitoring:** The DON/designees and/or the 100% of all documents related to the use of / on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. For a period of four months, the DON and are conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	8, 2016 and ongoing
C 217	Restraint/Seclusion/Time-Out-Post-Rest./Secl. After the use of or , staff	C 217		

Agency for Health Care Administration

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C 217	Continued From page 23 involved in an emergency safety intervention and the child shall have a face-to-face discussion, which is also known as a debriefing. Whenever possible, subject to staff scheduling, this discussion shall include all staff involved in the intervention. The child ' s parent or guardian shall be invited to participate in the discussion. The provider shall conduct the discussion in a language that is understood by the child and the child ' s parent or guardian. The discussion shall provide both the child and staff the opportunity to discuss the circumstances resulting in the use of or and strategies to be used by the staff, the child, or others to prevent the need for the future use of or . The discussion must occur within 24 hours of the emergency intervention, subject to the following exceptions: 1. Allowances may be made to accommodate the schedules of the parent(s) or legal guardian(s) of the child when they request an opportunity to participate in the debriefing and when staff deem their participation appropriate. 2. Allowances may be made to accommodate shift changes, vacation schedules, illnesses, and all applicable federal, state, and local labor laws and regulations. Chapter 65E-9.013(10)(a), F.A.C. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to conduct a debriefing session within 24 hours after the use of a and or with the resident and staff involved in the emergency safety and intervention and appropriate supervisory and	C 217	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or seclusion - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or - Requirement to fully document each use of and/or - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or seclusion - Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult.	, 2016

Agency for Health Care Administration

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C 217	Continued From page 24 administrative staff for 3 of 17 sampled residents reviewed for seclusions and (Resident #14, #16 and #17). The findings included: 1. Review, on of Resident #14's record revealed evidence of documentation that the resident had physical on from 6:18 PM to 6:27 PM; however, there was no evidence of documentation that the facility attempted to conduct a resident and staff/administrative debriefing after the In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings. 2. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid , but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of	C 217	**C 217 Continued** - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or seclusion and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification - Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of restraint and/or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint/seclusion. - Requirement to complete and document a debriefing session within 24 hours after use of restraint and/or seclusion with the staff involved in the emergency, safety, restraint and/or seclusion, and appropriate supervisory and administrative staff to review the circumstances resulting in the use of restraint and/or seclusion and strategies to be used by the staff, the resident, or others that could prevent further use of restraint/seclusion. If an injury is sustained by a resident during the use of restraint and/or seclusion, during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. - Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / .	

Agency for Health Care Administration

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Agency for Health Care Administration

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C 217	Continued From page 24	C 217	**C 217 Continued**	

administrative staff for 3 of 17 sampled residents reviewed for seclusions and (Resident #14, #16 and #17).

The findings included:

1. Review, on of Resident #14's record revealed evidence of documentation that the resident had physical on from 6:18 PM to 6:27 PM; however, there was no evidence of documentation that the facility attempted to conduct a resident and staff/administrative debriefing after the In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings.

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- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or seclusion and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /seclusion

- Revisions to the Restraint/Seclusion forms
- Documentation requirements related to /
- Expectations for full compliance to the Restraint/Seclusion policy and documentation requirements.

Agency for Health Care Administration

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	RC57000080	A. BUILDING: _____ B. WING _____	04/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 217	Continued From page 24 administrative staff for 3 of 17 sampled residents reviewed for seclusions and (Resident #14, #16 and #17). The findings included: 1. Review, on of Resident #14's record revealed evidence of documentation that the resident had physical on from 6:18 PM to 6:27 PM; however, there was no evidence of documentation that the facility attempted to conduct a resident and staff/administrative debriefing after the . In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings. 2. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at that time, leading into a common area that had a set of locked double doors. The area was void of	C 217	**C 217 Continued** Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by 8, 2016 will be required to complete the training before being allowed to return to work.	

Agency for Health Care Administration

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	RC57000060	A. BUILDING: _____ B. WING _____	04/08/2016

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SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

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C 217	Continued From page 25 any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including no evidence that the resident and staff/administrative debriefing occurred after the 3. Review of Resident #17's record on revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including no evidence that the resident and staff/administrative debriefing	C 217	**C 217 Continued** **Monitoring:** The DON/designees and/or the 100% of all documents related to the use of restraint/seclusion on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. For a period of four months, the DON and conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented √ to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	B, 2016 and ongoing

Agency for Health Care Administration

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C 217	Continued From page 26 occurred after the . In an interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility; the units were also locked and she inquired whether this was a .	C 217		
C 218	/Time-Out-Post-Rest./Secl. After the use of or , the staff involved in the emergency safety intervention, and appropriate supervisory and administrative staff, shall conduct a debriefing session that includes a review and discussion of: 1. The emergency safety situation that required the intervention, including a discussion of the factors that caused or preceded the intervention; 2. Alternative, less intrusive techniques that might have prevented the need for the or ; 3. The procedures, if any, that staff are to implement in the future to prevent any recurrence of the use of or ; and 4. The outcome of the intervention, including any injuries that resulted from the use of or and the treatment provided for those injuries. Chapter 65E-9.013(10)(b), F.A.C. This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to conduct the required debriefing session after the use of a .	C 218	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or seclusion - Requirement to fully document each use of and/or - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or	, 2016

Agency for Health Care Administration

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C 218	Continued From page 27 and or with the staff involved in the emergency safety and intervention and appropriate supervisory and administrative staff for 3 of 17 sampled residents reviewed for seclusions and (Resident #14, #16 and #17). The findings included: 1. Review on of the facility's policies and procedures titled " and " with the most recent review of revealed that the policies and procedures documented, "All staff involved in placing a resident in or , participants as well as witnesses and appropriate supervisory staff, are included in a staff debriefing discussion of what took place as soon as possible after the incident occurs. The Staff Debriefing Sheet will be completed and discussed no later than 24 hours after the event." Review, on of Resident #14's record revealed evidence of documentation that the resident had physical on from 6:18 PM to 6:27 PM; however, there was no evidence of documentation that the facility attempted to conduct a staff/administrative debriefing after the . In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings. 2. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated	C 218	**C 218 Continued** - Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult. - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification - Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of restraint and/or seclusion and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint/seclusion. - Requirements to complete and document a debriefing session within 24 hours after use of restraint and/or seclusion with the staff involved in the emergency safety restraint and/or seclusion and appropriate supervisory and administrative staff to review the circumstances resulting in the use of restraint and/or seclusion and strategies to be used by the staff, the resident, or others that could prevent further use of restraint/seclusion. If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.	

Agency for Health Care Administration

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C 218	Continued From page 27 and or with the staff involved in the emergency safety and intervention and appropriate supervisory and administrative staff for 3 of 17 sampled residents reviewed for seclusions and (Resident #14, #16 and #17). The findings included: 1. Review on of the facility's policies and procedures titled " and " with the most recent review of revealed that the policies and procedures documented, "All staff involved in placing a resident in or , participants as well as witnesses and appropriate supervisory staff, are included in a staff debriefing discussion of what took place as soon as possible after the incident occurs. The Staff Debriefing Sheet will be completed and discussed no later than 24 hours after the event." Review, on of Resident #14's record revealed evidence of documentation that the resident had physical on from 6:18 PM to 6:27 PM; however, there was no evidence of documentation that the facility attempted to conduct a staff/administrative debriefing after the . In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings. 2. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated	C 218	**C 218 Continued** - Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / The DON and and revised all medical records forms related to the documentation of the use of / to ensure that all required elements could be documented correctly and thoroughly. The DON, , and designees, along with Corporate Divisional Clinical Directors, provided retraining to all nurses, direct care staff, attending psychiatrists, and senior leadership on: - Definition of and appropriate justification for use of and/or during for an emergency safety situation - Revisions/clarifications to the / Policy including: • Who may authorize the use of and/or • Requirement to obtain a physician's order for any use of and/or • Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or • Requirement to fully document each use of and/or • Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention	, 2016 , 2016

Agency for Health Care Administration

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C 218	Continued From page 27 and or with the staff involved in the emergency safety and intervention and appropriate supervisory and administrative staff for 3 of 17 sampled residents reviewed for and (Resident #14, #16 and #17). The findings included: 1. Review on of the facility's policies and procedures titled " and " with the most recent review of revealed that the policies and procedures documented. "All staff involved in placing a resident in or , participants as well as witnesses and appropriate supervisory staff, are included in a staff debriefing discussion of what took place as soon as possible after the incident occurs. The Staff Debriefing Sheet will be completed and discussed no later than 24 hours after the event." Review, on of Resident #14's record revealed evidence of documentation that the resident had physical on from 6:16 PM to 6:27 PM; however, there was no evidence of documentation that the facility attempted to conduct a staff/administrative debriefing after the . In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings. 2. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated	C 218	**C 218 Continued** • Requirement to document the names of all staff involved in the and/or • Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult. • Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation • Need to notify the resident's legal guardian that the resident had a and/or and document that notification • Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /	

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C 218	Continued From page 27	C 218	**C 218 Continued**	

and or with the staff involved in the emergency safety and intervention and appropriate supervisory and administrative staff for 3 of 17 sampled residents reviewed for seclusions and (Resident #14, #16 and #17).

The findings included:

1. Review on of the facility's policies and procedures titled " and " with the most recent review of revealed that the policies and procedures documented, "All staff involved in placing a resident in or , participants as well as witnesses and appropriate supervisory staff, are included in a staff debriefing discussion of what took place as soon as possible after the incident occurs. The Staff Debriefing Sheet will be completed and discussed no later than 24 hours after the event."

Review, on of Resident #14's record revealed evidence of documentation that the resident had physical on from 6:18 PM to 6:27 PM; however, there was no evidence of documentation that the facility attempted to conduct a staff/administrative debriefing after the . In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Risk Manager, the participants acknowledged the findings.

2. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated

- Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of restraint/seclusion. If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record.
- Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /
- Revisions to the / forms
- Documentation requirements related to /seclusion
- Expectations for full compliance to the / policy and documentation requirements.

Agency for Health Care Administration

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C 218	Continued From page 27 and or with the staff involved in the emergency safety and intervention and appropriate supervisory and administrative staff for 3 of 17 sampled residents reviewed for seclusions and (Resident #14, #16 and #17). The findings included: 1. Review on of the facility's policies and procedures titled " and " with the most recent review of revealed that the policies and procedures documented, "All staff involved in placing a resident in or , participants as well as witnesses and appropriate supervisory staff, are included in a staff debriefing discussion of what took place as soon as possible after the incident occurs. The Staff Debriefing Sheet will be completed and discussed no later than 24 hours after the event." Review, on of Resident #14's record revealed evidence of documentation that the resident had physical on from 6:18 PM to 6:27 PM; however, there was no evidence of documentation that the facility attempted to conduct a staff/administrative debriefing after the . In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings. 2. Observations conducted on at approximately 9:25 AM, with the facility's Nurse Manager revealed an area that contained two , with doors in place; the doors opened out to a small common area that also contained a ; the area was separated	C 218	**C 218 Continued** Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work.	

Agency for Health Care Administration

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C 218	Continued From page 28 from a hallway that led to common areas by a set of double doors. The Nurse Manager reported, during an interview, on at approximately 9:25 AM that the facility had taken off the doors to the to avoid seclusions, but re-added them after a revision of their policies. Review on of the facility's own video recording revealed Residents #16 and #17 on at approximately 5:00 PM, locked away from other residents, in an area that they did not frequent as part of their daily routines. The residents were observed in the area that contained the two small , without doors at time, leading into a common area that had a set of locked double doors. The area was void of any furniture, except for a plastic chair. There was a staff member present in the area. The residents were observed kicking the double doors; the doors did not open when kicked. They were observed pacing back and forth in the area and this lasted at least 5 minutes. Review of Resident #16's record on revealed evidence of documentation that the resident was admitted to the facility on . The resident's record revealed evidence of documentation that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection and the facility discharged the resident at that time. Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including no evidence that the required staff/administrative debriefing occurred after the 3. Review of Resident #17's record on	C 218	**C 218 Continued** **Monitoring:** The DON/designees and/or the 100% of all documents related to the use of / on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. For a period of four months, the DON and are conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented /restraint to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly. **Responsible:** Director of Nursing	, 2016 and ongoing

Agency for Health Care Administration

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C 218	Continued From page 29 revealed that the resident was admitted to the facility on . The resident's record documented that the facility sent the resident to a receiving facility on accompanied by Law Enforcement officers after the resident disrupted the unit, instigated peers and was not responding to redirection. The resident's record revealed evidence of documentation that the facility re-admitted the resident on and discharged the resident on . Further review of the resident's record revealed no evidence that staff documented the ( ) intervention in the resident's record, including no evidence that the required staff/administrative debriefing occurred after the . In an interview conducted on at 12:03 PM with the facility's Risk Manager, the Risk Manager reported that the facility was a locked facility; the units were also locked and she inquired whether this was a .	C 218		
C 221	/ -Out-Post-Rest./Secl. Staff shall document in the child ' s record all injuries that occur during or as a result of an emergency safety intervention, including injuries to staff resulting from that intervention. Chapter 65E-9.013(10)(e), F.A.C. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to document the injuries after for 3 of 17 sampled residents (Resident #7, #14 and #15). The findings include:	C 221	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include:	, 2016

Agency for Health Care Administration

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C 221	Continued From page 30 1. Review of Resident #7's record on revealed evidence of documentation that the resident had a physical on . Further review of the resident's record revealed evidence of documentation that a nurse assessed the resident on at 6:30 PM, noted "red marks on the resident's right arm, skin intact, reddened area to left eye and back pain from a former injury that the incident had aggravated;" the "pain was" documented to be a "2 on scale of 1 to 10" however, there was no evidence of documentation of the source of the injury, any treatment in the packet, or nursing notes. There was no evidence of documentation that the nurse determined the extent of all injuries sustained during this and provided or secured the appropriate medical care promptly. The resident was no longer in the facility on . 2. Review of Resident #14's record on revealed evidence of documentation that the resident had a physical on from 4:18 PM to 4:22 PM. The record documented that the one-hour assessment by a Registered Nurse (RN) was conducted at 7:00 PM and the delay was because of an "ongoing crisis on the unit." According to the RN's assessment documentation, there were no injuries noted at that time; however, during the resident debriefing, on at 1:24 PM, the RN documented, "The back of by (sic) ear was ." A "late entry nursing note" for documented that the resident had superficial scratches on the arms. Resident #14 reported in an interview on at 3:26 PM that staff scratched the resident; that the resident sustained scratches from the , the resident's ear turned purple and stated that staff put ointment on the scratches;	C 221	**C 221 Continued** - Clarification on the definition of and - Who may authorize the use of and/or seclusion - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or - Requirement to fully document each use of and/or - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or seclusion - Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult. - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC57000080	A. BUILDING: _____ B. WING _____	04/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

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Agency for Health Care Administration

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Agency for Health Care Administration

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C 221	Continued From page 30 1. Review of Resident #7's record on revealed evidence of documentation that the resident had a physical on . Further review of the resident's record revealed evidence of documentation that a nurse assessed the resident on 2/28/16 at 6:30 PM, noted "red marks on the resident's right arm, skin intact, reddened area to left eye and back pain from a former injury that the incident had aggravated;" the "pain was" documented to be a "2 on scale of 1 to 10" however, there was no evidence of documentation of the source of the injury, any treatment in the packet, or nursing notes. There was no evidence of documentation that the nurse determined the extent of all injuries sustained during this and provided or secured the appropriate medical care promptly. The resident was no longer in the facility on . 2. Review of Resident #14's record on revealed evidence of documentation that the resident had a physical on from 4:18 PM to 4:22 PM. The record documented that the one-hour assessment by a Registered Nurse (RN) was conducted at 7:00 PM and the delay was because of an "ongoing crisis on the unit." According to the RN's assessment documentation, there were no injuries noted at that time; however, during the resident debriefing, on at 1:24 PM, the RN documented, "The back of by (sic) ear was ." A "late entry nursing note" for documented that the resident had superficial scratches on the arms. Resident #14 reported in an interview on at 3:26 PM that staff scratched the resident; that the resident sustained scratches from the , the resident's ear turned purple and stated that staff put ointment on the scratches;	C 221	**C 221 Continued** • Need to notify the resident's legal guardian that the resident had a and/or seclusion and document that notification • Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of ; • Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of . If an injury is sustained by a resident during the use of restraint and/or seclusion, during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. • Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of restraint/seclusion	

Agency for Health Care Administration

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C 221	Continued From page 30	C 221	**C 221 Continued**	

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2. Review of Resident #14's record on revealed evidence of documentation that the resident had a physical on from 4:18 PM to 4:22 PM. The record documented that the one-hour assessment by a Registered Nurse (RN) was conducted at 7:00 PM and the delay was because of an "ongoing crisis on the unit." According to the RN's assessment documentation, there were no injuries noted at that time; however, during the resident debriefing, on at 1:24 PM, the RN documented, "The back of by (sic) ear was ." A "late entry nursing note" for documented that the resident had superficial scratches on the arms. Resident #14 reported in an interview on at 3:26 PM that staff scratched the resident; that the resident sustained scratches from the , the resident's ear turned purple and stated that staff put ointment on the scratches;

- Revisions to the /Seclusion forms
- Documentation requirements related to /
- Expectations for full compliance to the / policy and documentation requirements.

Competency was assessed via post-tests maintained in individual employee's HR file. Each employee taking the training was also required to sign an attestation of his/her understanding of the expectations for compliance with established policy and documentation requirements. Nurses were additionally required to complete a correctly completed set of documents to verify understanding of the documentation requirements. Any employee failing to complete training by , 2016 will be required to complete the training before being allowed to return to work.

Agency for Health Care Administration

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C 221	Continued From page 31 however, a review of the resident's record on revealed no evidence of documentation related to the treatment. There was no evidence of documentation that the RN determined the extent of all injuries sustained during this and provided or secured the appropriate medical care promptly. 3. Review on of Resident #15's record revealed that the resident reported on , at the time of discharge from the facility, pain in the back, leg and arms, rated at 4-5 (with 10 being the highest pain on the scale). According to the resident's record, the resident had a physical on , but the resident and administrative debriefings were not conducted to assess whether the resident had sustained any injuries at that time. There was no evidence of documentation that the RN determined the extent of all injuries sustained during this and provided or secured the appropriate medical care promptly. In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings for Resident #7, #14 and #15.	C 221	**Monitoring:** The DON/designees and/or the 100% of all documents related to the use of / on a daily basis to ensure compliance with documentation standards and policy expectations. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. For a period of four months, the DON and are conducting daily random audits via surveillance camera of each residential unit's area with each area viewed at least 2 time periods each shift. Any incident of observed or is compared with documented / to ensure that all episodes are correctly documented. Aggregated results of the monitoring is reported monthly by the Director of Nursing to the facility PI Committee and quarterly to the Governing Body. Any non-compliance is addressed through retraining and/or disciplinary action as appropriate. When compliance is maintained for four months, the monitored will be decreased to a sample of each shift weekly.	8, 2016 and ongoing
C 222	Restraint/ -Out-Post-Rest./Secl. Staff involved in an emergency safety intervention that results in an injury to a child or staff shall meet with supervisory staff and evaluate the circumstances that caused the injury and develop a plan to prevent future injuries. Chapter 65E-9.013(10)(f), F.A.C. This STANDARD is not met as evidenced by:	C 222	**Responsible:** Director of Nursing	

Agency for Health Care Administration

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C 222	Continued From page 32 Based on record review and interview, the facility failed to have staff involved in that resulted in injuries meet with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further injuries for 3 of 17 sampled residents who suffered injuries during (Resident #7, #14, and #15). The findings include: 1. Review of Resident #7's record on revealed evidence of documentation that the resident had a physical on . Further review of the resident's record revealed evidence of documentation that a nurse assessed the resident on at 6:30 PM, noted "red marks on the resident's right arm, skin intact, reddened area to left eye and back pain from a former injury that the incident had aggravated;" the "pain was" documented to be a "2 on scale of 1 to 10" however, there was no evidence of documentation of the source of the injury, any treatment in the packet, or nursing notes. The resident was no longer in the facility on . The resident's record failed to revealed any evidence of documentation that the staff involved in the that resulted in the resident's injuries met with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further injuries. 2. Review of Resident #14's record on revealed evidence of documentation that the resident had a physical on from 4:18 PM to 4:22 PM. The record documented that the one-hour assessment by a Registered Nurse (RN) was conducted at 7:00 PM and the delay was because of an "ongoing crisis on the unit."	C 222	**Corrective Actions:** The Director Nursing (DON) and facility Risk Manager ( ) reviewed and revised the facility policy related to the use and documentation of and " and " to ensure that are required elements are included and clearly stated for staff interpretation. Key elements of the policy include: - Clarification on the definition of and - Who may authorize the use of and/or seclusion - Requirement to obtain a physician's order for any use of and/or - Requirement to conduct and document a face to face assessment of the resident no later than one hour after the initiation of the and/or seclusion - Requirement to fully document each use of and/or seclusion - Requirement to document in the medical record, the emergency safety situation that required/justified the use of and/or , the interventions used, and the outcome of the intervention - Requirement to document the names of all staff involved in the and/or seclusion - Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult.	

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C 222	Continued From page 33 According to the RN's assessment documentation, there were no injuries noted at that time; however, during the resident debriefing, on at 1:24 PM, the RN documented, "The back of by (sic) ear was ." A "late entry nursing note" for documented that the resident had superficial scratches on the arms Resident #14 reported in an interview on at 3:26 PM that staff scratched the resident; that the resident sustained scratches from the , the resident's ear turned purple and stated that staff put ointment on the scratches. The resident's record failed to reveal any evidence of documentation that the staff involved in that resulted in these injuries met with supervisory staff to evaluate the circumstances that resulted in these injuries and develop a plan to prevent further injuries. 3. 3. Review on of Resident #15's record revealed that the resident reported on , at the time of discharge from the facility, pain in the back, leg and arms, rated at 4-5 (with 10 being the highest pain on the scale). According to the resident's record, the resident had a physical on , but the resident and administrative debriefings were not conducted to assess whether the resident had sustained any injuries at that time. The resident's record failed to reveal any evidence of documentation that the staff involved in these that resulted in the resident's injuries met with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further injuries. In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings for Resident #7, #14 and #15.	C 222	**C 222 Continued** - Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation - Need to notify the resident's legal guardian that the resident had a and/or and document that notification - Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of restraint/seclusion. - Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. - Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of /	

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- Need to consult with the resident's treatment team physician for the and and to document that consultation including the date/time of the consult.
- Requirement for an MD or nurse to evaluate the well-being of the resident immediately after the resident is removed from and/or and to document that evaluation
- Need to notify the resident's legal guardian that the resident had a and/or and document that notification
- Requirement to conduct and document a face to face discussion with all staff and the resident involved in an emergency intervention. The discussion must include the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent the future use of /seclusion.

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SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 222	Continued From page 33 According to the RN's assessment documentation, there were no injuries noted at that time; however, during the resident debriefing, on at 1:24 PM, the RN documented, "The back of by (sic) ear was ." A "late entry nursing note" for documented that the resident had superficial scratches on the arms. Resident #14 reported in an interview on at 3:26 PM that staff scratched the resident; that the resident sustained scratches from the , the resident's ear turned purple and stated that staff put ointment on the scratches. The resident's record failed to reveal any evidence of documentation that the staff involved in that resulted in these injuries met with supervisory staff to evaluate the circumstances that resulted in these injuries and develop a plan to prevent further injuries. 3. 3. Review on of Resident #15's record revealed that the resident reported on , at the time of discharge from the facility, pain in the back, leg and arms, rated at 4-5 (with 10 being the highest pain on the scale). According to the resident's record, the resident had a physical on , but the resident and administrative debriefings were not conducted to assess whether the resident had sustained any injuries at that time. The resident's record failed to reveal any evidence of documentation that the staff involved in these that resulted in the resident's injuries met with supervisory staff to evaluate the circumstances that resulted in the injuries and develop a plan to prevent further injuries. In an interview conducted on at 1:54 PM with the facility's Risk Manager and the facility's Nurse Manager, the participants acknowledged the findings for Resident #7, #14 and #15.	C 222	**C 221 Continued** • Requirement to complete and document a debriefing session within 24 hours after use of and/or with the staff involved in the emergency safety and/or and appropriate supervisory and administrative staff to review the circumstances resulting in the use of and/or and strategies to be used by the staff, the resident, or others that could prevent further use of / . If an injury is sustained by a resident during the use of and/or , during the debriefing a plan to prevent further injury is to be developed and documented in the medical record. • Requirement to obtain and document medical treatment promptly for any injury sustained by a resident during the use of / . - Revisions to the / forms - Documentation requirements related to restraint/seclusion - Expectations for full compliance to the /Seclusion policy and documentation requirements.	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	RC57000060	A. BUILDING: _____ B. WING _____	04/08/2016

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SANDY PINES	11301 SE TEQUESTA TERRACE TEQUESTA, FL 33469

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RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

FED-EX OVERNIGHT 8086 3829 3602
SIGNATURE REQUIRED

, 2016

Administrator
Sandy Pines
11301 Se Tequesta Terrace
Tequesta, FL 33469

RE: CCR# 2016000932, CCR# 2016002253, CCR# 2016002383, CCR# 2016002918, CCR# 2016003021 and CCR# 2016003061

Dear Administrator:

This letter reports the findings of a complaint survey that was commenced on , 2016 and concluded on , 2016 by a representative of this office.

Attached is the provider's copy of the State (3020) Form, which indicates the deficiencies that were identified during the visit.

Please provide a plan of correction to this Field Office, in accordance with enclosed instructions, for the identified deficiencies **within ten calendar days of receipt of this report. All deficiencies shall be corrected no later than , 2016.**

The plan of correction must include the following:

1. Identify how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
2. Describe how the facility will identify other residents having the potential to be affected by the same deficient practice.
3. Explain measures to be put into place or systemic changes made to ensure that the deficient practice will not recur.
4. Identify how the facility will monitor its corrective action to ensure the deficient practice is being corrected and will not recur; i.e., what program will be put into place to monitor the continued effectiveness of the systemic change.
5. Ensure that no protected or other confidential information (i.e., resident or staff names) are included in the plan.
6. State the completed date; the date that the facility identifies compliance can be achieved, which must be after the exit date.
7. You must sign the bottom of page 1 of the statement of deficiencies; include your title and date.

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL
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Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD
Enclosure:State Form 3020

TBB2